Before the
Federal Communications Commission
Washington, D.C. 20554

In the Matter of	)	
	)	
Promoting Telehealth for Low-Income Consumer	)	WC Docket No. 18-213
	)	
	)	

COMMENTS OF SAGE TELECOM COMMUNICATIONS, LLC
D/B/A TRUCONNECT IN RESPONSE TO
PROPOSED CONNECTED CARE PILOT PROGRAM

I. INTRODUCTION.

Sage Telecom Communications, LLC d/b/a TruConnect ("TruConnect"), by counsel, hereby submits these comments pursuant to the Federal Communications Commission's ("FCC" or the "Commission") Notice of Proposed Rulemaking ("NPRM") published on July 28, 2019.[1]

TruConnect recommends the following objectives and focus for the Connected Care Pilot Program ("Pilot" or "Pilot Program") and submits proposed answers to questions and responses to statements made in the NPRM seeking public input on issues such as the pilot program's structure and design, eligibility for participation, accountability measures, legal authority to act and state barriers to overcome.

II. OVERVIEW OF TRUCONNECT COMMENTS.

This telehealth pilot program is a very important initiative. The government has a role creating the most favorable environment and incentives to meet the need to more quickly advance telehealth services to improve healthcare delivery and access to world-class healthcare for all Americans. This is about saving lives and also saving money for patients, providers and taxpayers. There are many issues to explore and lessons learned from prior government telecommunications initiatives in order to design a worthwhile and effective pilot program. The method of connectivity (broadband, wireless, and fixed, or mobile), incentives

[1] *Promoting Telehealth for Low-Income Consumers,* Notice of Proposed Rulemaking, released July 11, 2019, WC Docket No. 18-213 ("NPRM").

to offer, the stakeholders to include, and program design and eligibility are important. It is also important to clearly define the goals the Commission seeks to accomplish because it is all important to "get it right". This Connected Care Pilot Program should not use taxpayer USF funds to do what the private sector is doing or can do with the right telehealth incentives.

Many telehealth initiatives like some of those contemplated in the proposed Pilot require changes in state laws to address legal barriers, to increase reimbursement payments, to grant authority for providers, and to grant permission to access patients' personal health information. The Commission must also consider the types of incentives to incorporate, if any, by examining other federal and state incentive-based programs, especially those that are healthcare related. The Commission should also define how interconnectivity and interoperability of software communications might work between physicians and patients. They should also review other pre-existing services and programs, so money is not wasted on duplicative initiatives, services or devices that either the private or public sectors already provide. Also, it is valuable to analyze other successful funding pilot models, federal agency models for accountability of federal funding, interoperability of healthcare software programs, and how best to leverage existing federal programs within the agency, such as Lifeline, which serves the very same targeted population this Pilot intends to benefit. The FCC-based Lifeline program already provides the necessary connectivity to many low-income Americans. If they have difficulty accessing the internet, it is usually a broadband deployment issue rather than affordability. Broadband deployment is outside the scope of this proposed Pilot. Thus, there is no need to create a Telehealth Lifeline 2.0 when some of the necessary "infrastructure" to serve the targeted populations is already in place.

III. PILOT PROGRAM STRUCTURE AND ELIGIBILITY.

Since time and funds are somewhat limited for a pilot, the Commission should not attempt too much or open the focus too wide if this Pilot is to succeed and produce worthwhile data. Narrowing the focus to under-served and unserved communities easily defined in census block statistics and limiting healthcare

providers to those which serve a rather high percentage, thirty percent or more, of Medicaid-eligible patients will help deliver necessary continuity of providers and healthcare for a vulnerable population. Allowing or encouraging the use of mobile wireless devices and applications also improves the Pilot design as well as access to and ease of healthcare delivery. A Pilot designed this way will have a greater impact and will produce valuable measurable and qualifiable data to determine and compare outcomes and success for this population and with the providers who serve them. Moreover, such a focus will improve the likelihood that the results and data will help the Commission assess future opportunities and long-term program designs.

Comments were requested about who should be eligible to participate in the Pilot, including the types of eligible health care providers and broadband service providers. The NPRM proposed that the Connected Care Pilot would operate as a new program within the Universal Service Fund ("USF"), which would provide funding to eligible health care providers to defray the qualifying costs of providing connected care services to low-income Americans and veterans. TruConnect agrees that the Pilot should operate separately from—but in conjunction with—other existing USF programs, in order to not duplicate efforts but to also gain efficiencies where possible by determining how the programs can work in tandem. However, TruConnect strongly urges the Commission not to limit the Pilot or eventual Connected Care program to provide funding *only* to eligible health care providers, as it is in many cases the *patients* who need subsidized broadband access to facilitate the physician-patient connection, and such access may be more efficiently provided through a carrier. The NPRM acknowledged that lack of patient broadband Internet access service is cited as a key obstacle for health care providers and patients in adopting connected care services.[2]

[2] NPRM ¶ 13.

We recommend that the Pilot accept applications from an array of different groups to increase the number of proposals and Pilot designs to provide the Commission a plethora of various telehealth delivery applications to review. Moreover, if the focus is on low income Americans and especially elderly and veterans living in rural America, then the Pilot should not exclude awards for qualified Eligible Telecommunications Carriers ("ETC"), especially non-facilities based ETCs, partnering with healthcare providers who already serve this very population (facilities-based ETCs typically serve other demographics because their margins are higher with those customers). Commissioner O'Rielly recognized in the Notice of Inquiry that existing FCC-approved programs should be included in the Pilot since clear authority and Commission infrastructure already exists.[3] As discussed further herein, many patients can obtain broadband access through the Lifeline program (and such connectivity should not be duplicated under the Pilot), and Lifeline carriers should be allowed to participate in the Pilot in order to provide any additional services necessary to promote telehealth (i.e. upgraded devices and services not otherwise covered by Lifeline funding). Permitting funding directly to the carriers, and not just healthcare providers, would bring efficiencies to the Pilot by targeting consumers already determined to be eligible, and because carriers could partner with multiple healthcare providers, whether or not the providers are eligible to receive funding through the Pilot.

Many groups provided comments to the Notice of Inquiry about the expense and prolonged time it requires to buildout broadband infrastructure due to requirements like design, local permitting and construction timelines.[4] We agree that this Pilot should and cannot take on that time and financial intensive challenge. Already the private sector plus state and federal government programs, like the Commission's rural broadband program, have created broadband and wireless deployment initiatives. This month the

[3] *Promoting Telehealth for Low-Income Consumers,* Notice of Inquiry, 33 FCC Rcd 7825, 7825-26, Statement of Commissioner Michael O'Rielly (2018) (*Notice of Inquiry*).

[4] NPRM ¶ 36.

Commission announced its Rural Digital Opportunity Fund Notice of Inquiry seeking comments on expanding its rural broadband focus.[5] Many of the necessary wireless infrastructure upgrades and buildout, therefore, may already be included in other programs and should not be duplicated but rather leveraged without allotting Pilot funds.

The NPRM requests comments about the types of applicants that can qualify to participate. We recommend limiting hospital-based healthcare providers to hospitals and their affiliates with a Medicaid patient population exceeding thirty (30) percent or uncompensated care exceeding thirty (30) percent of their patient population. We also recommend prioritizing hospitals with fewer than 100 beds. Applicants should be required to document these statistics for at least the prior three (3) years. "Non- profit" hospitals, especially those exceeding 100 beds, should not be qualified to participate. Most of the largest hospitals in America are deemed non-profit, however, they may not predominately serve the Pilot's targeted demographic. Furthermore, since this is a limited Pilot, limiting eligible hospitals this way helps ensure more rural community-based hospitals are included in this Pilot.

And, it is not wise to provide financial support to pay the internet charges for "just anyone who asks", i.e. hospitals, clinics or individuals, without first establishing eligibility criterion and verifying the same. In order to avoid duplication, the Commission should require applicants to confirm they do not or cannot afford to obtain broadband at the time of their application and that support, as contemplated under this Pilot, will make broadband affordable for them. Patients given financial assistance under a Pilot should be required to comply with the same criteria and extensive eligibility verification procedures currently required for Lifeline recipients. The National Lifeline Eligibility Verifier ("National Verifier") was developed to protect taxpayer dollars against waste, fraud and abuse and ensure participants' eligibility.

[5] *Rural Digital Opportunity Fund,* Notice of Inquiry, dated August 1, 2019.

This Pilot should do the same. The Pilot's integrity depends on it and taxpayers deserve it. This objective can be met if the Lifeline ETCs are eligible to be part of the Pilot perhaps in "partnership" with eligible healthcare providers because Lifeline customers are already verified as eligible.

The Commission should also consider requiring corporate participants to contribute perhaps 20 percent of the gross cost of their approved project to be matched with Pilot program funds. This will enable the FCC to spread Pilot funds further to select more participants offering different types of proposals from different geographic regions using different technologies and telehealth delivery modalities. The Commission may wish to use a sliding match scale dependent upon the financial size of the participating company or healthcare provider. For example, the Commission might consider issuing $5 million to one awardee and $7 or 8 million to another awardee to account for the size and scope of each proposed project. The Commission should also encourage joint venture ("JV") type arrangements between eligible participants to leverage expertise and technologies and to improve outcomes. If a JV relationship is planned, it should be disclosed in the Pilot bid application detailing their individual contributions, use of funds and elements or scope of their joint efforts. A short ramp up time for awardees of perhaps sixty (60) days is wanted, as discussed in the NPRM. The allowed ramp-up time should be focused on administrative type compliance and coordination activities with the Commission rather than finding a partner. Furthermore, we recommend that the Commission's funding be distributed over the three (3) year term and not all at once. This funding distribution method provides more accountability and allows the Commission to continue to monitor the Pilot awardee, their reporting and compliance methods, documented use of funds, and possibly the program milestones achieved, so that if needed, funding could be cut off or other actions taken to avoid wasting taxpayers moneys on "troubled" projects. This is one of those lessons learned from the Broadband Stimulus program several years ago.

The NPRM also requests comments on the health conditions on which to focus. This may be complicated to achieve since heading off certain health conditions, especially chronic ones, early with

wellness visits, continuity of healthcare and other proactive solutions often produces better patient health outcomes and can avoid chronic sicknesses. Truly helping develop a healthcare delivery system rather than a sick care system saves more lives and money. So, "catching" and treating certain health conditions early – those conditions known to lead to chronic illnesses – should be considered. Allowing a certain portion of Pilot funds to be directed to more preventative care (which could be limited to participants with early markers or risk factors for certain conditions) would still preserve the majority of funds for the chronic, epidemic-type health conditions mentioned in the NPRM,[6] while not completely excluding the valuable data that could be derived from including preventative care at some level, and the resulting cost savings which could be compared to participants for whom such conditions were not treated until later or without access to telehealth. Also, documentation through patient medical records should be required to help determine a participants' Pilot eligibility. This criterion and the steps following this determination as well as the logistics and time required may create a time lag for certain awardees. However, the data produced effectively tracking health outcomes for these types of patients may be extremely helpful. A mobile wireless device or wireless based application is one of the best solutions to meet this objective.

It is also wise to ensure that the geographic focus is narrow and consistent with the Pilot's objectives and reality of the limited time period and funding limits. This should not be a telehealth pilot to encourage telehealth in general. That type of program could become a temporary short-lived money grab and may not even provide realistic or helpful data. This Pilot is better suited for a design that will explore viable and effective initiatives and program designs to incorporate into a more permanent program that will be designed to improve connectivity and healthcare access for people in areas that lack it. The Pilot should focus on unserved areas and tribal lands across the country where viable access to healthcare has been poor

[6] NPRM ¶ 17: "we propose limiting the Pilot program to projects that primarily focus on health conditions that typically require at least several months or more to treat—such as behavioral health, opioid dependency, chronic health conditions (e.g., diabetes, kidney disease, heart disease, stroke recovery), mental health conditions, and high-risk pregnancies."

for generations. Statistics also reveal that the people living in these areas tend to have higher rates of diabetes, heart disease, obesity and other related health issues. Therefore, improving access to healthcare and continuity of healthcare in these communities is extremely beneficial, and will save lives and perhaps save some rural hospitals. These regions will benefit the most from a temporary pilot, and the data collected will be most applicable for future use.

Statistics reveal that on average approximately 22.5 percent of rural Americans rely on Medicaid for health coverage.[7] Over 5 million veterans live in rural communities and 41 percent of them struggle with service-related disabilities and also rely on Medicaid or VA benefits, or both.[8] And nearly one-third of dual eligible seniors, low-income seniors and people with disabilities rely on both Medicaid and Medicare. Additionally, workers in rural areas tend to make less and are less likely to get health insurance through their employer. As a result, Medicaid is an important source of health coverage for many rural Americans.[9] The advancement of telehealth and the mechanism to incent adoption is important to both rural hospitals but also to rural physicians. The evidence reveals that across the country there exists a great need for more primary care physicians, and this is most prevalent in rural communities.[10] In these

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[6] United States Department of Agriculture Economic Research Service, "Rural America at a Glance, 2016 Edition," Economic Information Bulletin 162, November 2016, available online at https://www.ers.usda.gov/webdocs/publications/eib162/eib-162.pdf; and, Vann Newkirk, The Affordable Care Act and Insurance Coverage in Rural Areas (Washington, DC: Kaiser Family Foundation, May 29, 2014) online at http://kff.org/uninsured/issue-brief/the-affordable-care-act-and-insurance-coverage-in-rural-areas/.

[7] Jennifer Haley, et al., Veterans and Their Family Members Gain Coverage Under the ACA, But Opportunities for More Progress Remain (Washington, DC: The Urban Institute, September 2016) online at http://www.urban.org/sites/default/files/publication/84441/2000947-Veterans-and-Their-Family-Members-Gain-Coverage-under-the-ACA-but-Opportunities-for-More-Progress-Remain.pdf.

[8] Damico, Anthony and Vann Newkirk, "The Affordable Care Act and Insurance Coverage in Rural Areas." Kaiser Family Foundation. May 29, 2014, online at http://kff.org/uninsured/issue-brief/the-affordable-care-act-and-insurance-coverage-in-rural-areas/.

[9] Bailey, Jon, "Medicaid and Rural America." Center for Rural Affairs, No. 15. February 2012, online at http://files.cfra.org/pdf/Medicaid.pdf.

communities, physicians of every specialty often leave for bigger cities, merely to make ends meet. A telehealth pilot that works and is focused on rural communities and healthcare delivery will enable these physicians to care for more patients, which increases their earnings and helps them continue to serve these areas. For these reasons, rural hospitals are critical to rural communities and Medicaid is critical to those hospitals. Rural hospitals not only are an important source of care, they are often the largest local employer.[11]

Rural geographic areas can be identified by researching census data blocks to determine low broadband and wireless adoption areas coupled with demographics and Medicaid enrollee rates. If the Pilot is limited this way, it will increase the likelihood that the Pilot's objectives are accomplished and that the data collected can be used to truly learn best practices to effectively deliver world class healthcare to similar communities with those technology and delivery methods.

It is also important to consider that if both served and under-served regions are included, then time and moneys do not allow a temporary pilot program to achieve very much. Also, this may unnecessarily open the opportunity for criticism because of a flawed Pilot design, and the opportunity to obtain worthwhile results or data for use designing a permanent program may be lost. This does not necessarily mean that all served areas have viable telehealth services; it merely reflects the reality of implementing a limited pilot program with an objective to create the best test model to gather beneficial information to design a permanent program at a later date. In addition, the Commission may not have legal authority to support federal funding for served areas or to give money to companies and individuals residing there without establishing numerous restrictions, eligibility requirements and compliance measures that require time to develop and implement before the Pilot can be launched.

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[11] Lindsey Corey, "Press Release: New report indicates 1 in 3 rural hospitals at risk," National Rural Health Association, February 2, 2016, online at https://www.ruralhealthweb.org/NRHA/media/Emerge_NRHA/PDFs/02-02-16PI16NRHAreleaseoniVantagestudy.pdf.

Mobile devices are important to the delivery of healthcare since people do not only get sick at home. Mobile devices, tablets and computers are equally as important for patients to access healthcare services. In fact, we know that the use of telehealth applications on smartphones and devices helps improve the health and wellness for people who use them. This will especially help rural patients who typically must travel great distances to obtain care. Therefore, in general, rural residents often delay wellness visits so that when they do visit a provider, they are often sicker and require more expensive treatments. For these people especially, telehealth can really improve their lives.

Rural America has a higher population of low-income earners. Many are eligible and already participate in the existing Lifeline program. Therefore, the Lifeline program can and should be used to serve them. Partnerships with ETCs should be encouraged or at least allowed since Lifeline subscribers already receive financial support for affordable phone and broadband services, often with carriers that provide free or discounted 3G or 4G/LTE mobile devices that can be used to deliver telehealth care. On many existing Lifeline devices, telehealth, including video conferencing, can be very adequately delivered with 2 gigabytes ("GB") of monthly data (the current minimum service standard for mobile broadband). As a result of the Commission's net neutrality reversal, an increased monthly data allotment is not necessary because carriers are allowed to "white list" healthcare providers so patients can freely access doctors and designated healthcare programs on the internet without using up their allotted monthly data. For these reasons, this existing FCC program and service should not be duplicated in this Pilot by creating a Telemedicine lifeline 2.0 type program. In fact, if Lifeline ETCs are specifically encouraged to participate, then the Pilot funding may serve even more people, and/or allow Pilot funds to stretch further and provide a higher level of service (i.e. consistent connectivity or more frequent video connectivity) for certain patients.

A further, rather convincing financial analysis that supports narrowing the Pilot's focus to include lower income veterans and elderly Lifeline-eligible subscribers, is the potential tremendous health care

savings in the hundreds of millions of dollars for *just* reduced hospital emergency department visits. The Veterans Health Administration (VHA) conducted a telemedicine pilot program with 900 patients in the last decade and found there to be a 40 percent reduction in emergency department visits thanks to the telemedicine program. Using telemedicine for Lifeline participants could result in savings borrowing from the continued telemedicine success of the VHA. The Centers for Medicare and Medicaid (CMS) reported there were 16.7 million hospital emergency department visits for Medicare recipients age 65 or older in 2017, and the CMS data shows that, on average, there were 2.77 emergency department visits per recipient.[12] If a telemedicine program were implemented for Lifeline-eligible persons over the age of 65 and the initiative was as successful as the VHA program, then 1.1 emergency department visits could potentially be avoided for *each* elderly participant in this Pilot, cutting healthcare visits by almost 40 percent and resulting in an even higher cost savings, given the higher cost of care in the emergency setting.

As of May 2019, industry data shows there were 8.43 million Lifeline Program subscribers. Assuming that the 65 or older population is only a quarter of the Lifeline participants would mean there were 2.11 million elderly Lifeline participants. If this Pilot includes people over 65 on Lifeline and *only* 5 percent of them participated in the Pilot, then there could be $187 million in emergency department annual cost savings, assuming an average emergency department cost of $1,596 per patient.[13] If 10 percent of the Lifeline elderly participated, then the cost savings could be $373 million every year. These are projected savings using the existing Lifeline program and infrastructure.

Furthermore, according to the Association of American Veterans, as of December 2017, 10 percent to 13 percent of Lifeline participants were veterans. This means approximately 970,000 veterans participate in Lifeline. If just 5 percent of these Lifeline-eligible veterans participated in the Pilot and the

[12] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/2017/2017_Utilization.html.

[13] https://www.usatoday.com/story/news/health/2019/06/04/hospital-billing-code-changes-help-explain-176-surge-er-costs/1336321001/.

same VHA success rate applied, and assuming that Lifeline veterans currently *only* visit the emergency room once a year, then annually $31 million in healthcare costs could be avoided. Using these same assumptions derived from the CMS and VHA reports, if 5 percent of all Lifeline participants participated in this Pilot and each participant visits the emergency room only once a year – less than the reported 2.77 average number of annual emergency department visits – then approximately $269 million could be saved each year. If the number of Pilot participants who are also Lifeline-eligible doubled to 10 percent, then $538 million could potentially be saved on emergency room visits if successful. In one year, this $100 million Pilot would pay for itself more than five times. These participation estimates were based on a lower participation rate than actually expected in order to make the point that Lifeline ETCs and their subscribers must be included as eligible Pilot awardees.

A. PILOT PROGRAM INCENTIVES.

The incentives created in the Pilot must align with its stated focus and goals. That is obvious but not always done or required in the design of some programs. Therefore, the preferred method to incent government-supported expensive and complex initiatives in which the public sector has expertise and already operates are public-private partnerships. They best align the interests of participants which receive taxpayer funds to enhance existing private sector services. For these reasons, the Commission should establish clear qualifications for companies to participate and receive federal funding. Eligibility qualifications should include proven telecommunications or healthcare experience, financial stability and some track record serving the targeted individuals with either healthcare or telecommunications-based services.

Also consider that a successful pilot may not actually require excessive funding for telehealth technology device applications. Again, for example, if Lifeline carriers including non-facilities based ETCs are eligible to participate, then those ETCs can include telehealth applications on devices at fairly low costs compared to other telehealth proposals because they already offer the necessary telecommunications

service to low-income Americans. Some ETCs already provide these types of telephone telehealth applications. We recommend that the Pilot requires patient participants to stay with one healthcare provider or ETC. This requirement is very important to incorporate because patients switching between Pilot awardees, if that is possible, makes it difficult to collect accurate data.

We also recommend not allowing direct customer subsidies or funding. Providing funds directly may violate federal law and creates a plethora of accountability, fraud and abuse issues that can largely be avoided. Company recipients of funds are better suited to report and track funds than requiring and expecting that every individual will self-report receipts, purchases, etc. Furthermore, it would take years to market and attract people to join a temporary pilot, to teach them how to apply, to verify eligibility and then set up systems to track and account for the use of individual funds. Nor does the government have authority to directly fund devices, software, equipment, etc., nor authority to fund equipment and software updates, or account for and replace lost, stolen and damaged equipment.

A Pilot applicant's ability to sustain their program without additional government subsidies after the three-year Pilot should also be considered. And, infrastructure development, deployment and funding of computers, software, laptops, and smartphones is not the government's role, especially long term. Necessary funding for development and device purchases and updates cannot be sustained. Thus, sustainability of any "program" created by this Pilot should be considered and fully explored.

B. PILOT PROGRAM JURISDICTION.

To prevent program duplication or acting outside the Commission's authority, the FCC should work to develop a coordinated pilot or more permanent telehealth program with another federal agency after this more limited pilot concludes. The broadband stimulus initiative implemented through USDA Rural Utilities Service ("RUS") agency and National Telecommunications and Information Administration ("NTIA") provides many valuable lessons to either use or avoid. Funds were wasted, and very little sustainable infrastructure survives. That program should be closely examined and perhaps the FCC should

emulate best practices learned.

Several other federal agencies also claim jurisdiction over broadband and telecommunications. They have initiatives to build-out rural broadband infrastructure and to encourage digital communications. RUS, NTIA and US Health & Human Services Departments Digital Communications Division ("DCD") are involved and have such programs or ongoing initiatives. In designing this pilot, the existing FCC programs and initiatives, like Lifeline, should be prioritized and used in this pilot to insure the Commission operates within the law. It may be possible to develop a multi-agency pilot later similar to the broadband stimulus BTOP and BOP initiatives (but one that works) if a broader joint program is desired.

Furthermore, to be eligible for this Pilot, corporate participants should be required to show prior experience providing telecommunications or telehealth related services. They should have the demonstrated financial capability to match federal funding, as required, and they should have the existing infrastructure in place to deliver the intended services so "going live" is not delayed. Corporate participants should be allowed to partner with each other formally or informally to create a joint application to participate in the Pilot to advance a broader or more robust initiative. As stated previously, the Pilot should focus exclusively on low-income rural Americans such as those eligible for current government-based programs like Medicaid and the veterans who qualify for cost-free healthcare through the Department of Veterans Affairs.

The same federal eligibility and on-boarding technologies and procedures required in other federal programs should be used because they are proven to work and screen out non-eligible applicants. Time is limited in a Pilot, so if the on-boarding process is slow, multifaceted or cumbersome, then many targeted individual Pilot program participants may not be reached or served. Simply a verification system that works should be required to root out waste, fraud and abuse and help insure focus on the intended patient populations.

IV. STATE BARRIERS TO OVERCOME.

States have erected numerous barriers to practicing medicine or providing healthcare services if a healthcare provider does not hold that state's license. These barriers limit providers coming across state lines, either physically or virtually, to deliver healthcare including examining, treating and prescribing for patients using most telehealth technologies without that state's authority. States also establish limits on authorized scopes of practice for healthcare providers. Scope of practice limits differ from state to state. Medicare and some Veterans Administration services recently became exempted from such requirements. In addition, many state Medicaid programs restrict or reduce reimbursements for telehealth services as do many private health insurance companies. For the healthcare provider serving other private pay populations, it will take quite some time to pass necessary state licensing changes loosening scopes of practice restrictions or opening licensing even for telehealth. The issues are controversial and have strong opponents. This is important to consider. Note that these same barriers do not exist for many portable or remote monitoring devices or with many smart phone applications used to track and report on blood sugar levels for diabetics, heart monitors, blood glucose levels, blood pressure, etc. Therefore, greater focus on remote monitoring devices, awardees using in-state providers, and focus on Medicaid and veteran benefits eligible participants will produce better health outcomes and enhance continuity of care.

If a hospital-based provider is included in the Pilot, then note that other hurdles exist such as paying for the added cost and training to incorporate telehealth services into hospital-based medical practice. To fully overcome these hurdles or incent hospital and healthcare provider participation, not only must reimbursements increase, one must also realize that issues exist such as: funding for necessary equipment and technology, equipment reliability, technical training for physicians and care providers, expensive IT support and software updates, patient privacy, security of electronic data, HIPPA security issues, interoperability of virtual healthcare technologies with existing physician software (which varies among specialties), possible increased medical errors, required new hospital privileges to deliver care, and medical

malpractice insurance coverage for telehealth. Moreover, the healthcare provider must believe it's worth their time and expense to incorporate telehealth services in their delivery of care. So far that has not been an easy sell.

V. SUMMARY.

The wise use of new technology has the potential to dramatically improve both access to healthcare and the quality of care in rural communities. A test pilot program that is too broad in scope will not allow enough time or offer enough financial incentives, especially long term, to encourage patient participation in the pilot nor to incent greater use of telehealth or integration into physicians' and hospitals' healthcare delivery systems. A pilot program that is not narrowly targeted and only offers temporary funding will be seen as such and may not attract the participants who are needed to complete an effective telehealth pilot program. Therefore, the Pilot's design and focus is extremely important to develop and communicate to produce the intended results and provide quality data for the Commission's use to design a more permanent program. For these reasons and those stated above, we applaud the Commission initiating a telehealth pilot program and recommend consideration and incorporation of our comments into the design of the final Pilot.

Pursuant to section 1.415 and 1.419 of the Commission's rules, these Comments are being filed electronically.

Respectfully submitted,

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